1987 Missouri
BLUE RIBBON COMMISSION
on Formulary Assessment

Final Report

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LETTER OF TRANSMITTAL

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Michael V. Reagen, Ph.D., Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, Missouri 65102

Dear Dr. Reagen:

We are pleased to present to you the final report of the Blue Ribbon Commission on Formulary Assessment.

On behalf of all the members of the Commission, we commend you for your wisdom in recognizing the need for an indepth review of the Medicaid Drug Program, your openness in providing needed information, and your fairness in insuring that all interested groups had an equal opportunity to participate in the process. We urge you to carefully consider our recommendations and take whatever actions are at your disposal to implement them in an expeditious manner.

Thank you for permitting us to be a part of this important endeavor.

Respectfully Submitted,

James J. Mongan, M.D., Co-Chair
Executive Director
Truman Medical Center

Virginia Weldon, M.D., Co-Chair
Deputy Vice Chancellor for
Medical Affairs
Washington University School
of Medicine

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INTRODUCTION AND ACKNOWLEDGEMENTS

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Purpose:

This report addresses a range of issues regarding the provision of pharmaceuticals through the Missouri Medicaid program. It was developed by an ad hoc commission appointed by Michael V. Reagen, Ph.D., Director of the Missouri Department of Social Services and comprised of persons representing business, labor, agri-business, health care providers, insurers, pharmaceutical manufacturers and consumers. The Commission was formed to conduct an independent study of the Medicaid pharmacy program -- to evaluate how Missouri's Medicaid program compares to those in other states, and to other health insurers in Missouri; and to provide the Department of Social Services with recommendations based on the experience of the private sector. The Commission was charged with the tasks of (1) conducting a thorough review of current procedures used for Medicaid drug reimbursement, (2) identifying positive and negative aspects of current policies and procedures, and (3) making recommendations to improve the program. The Commission was also directed to specify options and strategies for implementation of their proposals.

This report summarizes the findings and recommendations of the Commission.

Process:

The Commission was headed by two co-chairs: James J. Mongan, M.D., Executive Director of Truman Medical Center, and Virginia V. Weldon, M.D., Deputy Vice Chancellor for Medical Affairs, Washington University School of Medicine. It was organized into three subcommittees, each responsible for analyzing one facet of the Medicaid drug program. The subcommittees addressed (1) drug reimbursement methodology, (2) policy and procedures of formulary revision, and (3) the fiscal impact of formulary expansion.

Background papers were prepared for each of the three subcommittees with the assistance of technical advisory groups. The technical advisory groups were made up of Medical Advisory Committee members, drug manufacturer representatives, physicians, health care coalition representatives, and consumer advocates. The subcommittees examined alternative approaches and suggested program changes (or re-affirmed current procedures) in reports to an executive committee comprised of the two co-chairs and the chair and vice-chair of each subcommittee. The executive committee reviewed subcommittee reports, synthesized their conclusions, and developed a preliminary report. Following a review of the preliminary report with staff of the Division of Medical Services, this final report was prepared.

During the course of the Commission's work -- after the subcommittees had completed their work -- the Health Care Financing Administration (HCFA) issued new regulations governing Medicaid reimbursement for drugs. The effect of these changes was to limit aggregate spending on a substantial number of multi-source drugs. The executive committee discussed the revised regulations, considered their impact on State procedures and funding, and modified subcommittee proposals to reflect these changed circumstances.

Acknowledgements:

This report represents many hours of effort on the part of Commission members and other concerned Missourians.

The subcommittees and the executive committee met many times to hear presentations, discuss issues and to review drafts between May 1987 and December 1987. Testimony was provided by recipients, health care providers, consumer advocates and others interested in improving access to quality care in Missouri. The Commission would like to acknowledge the contribution of all the individuals who participated in this process and would like to single out Ed Neuschler, Senior Fellow, National Governors' Association, and Richard W. Fowler, National Pharmaceutical Council for their special contributions.

The Commission would also like to acknowledge the efforts and time devoted by the members of the technical assistance groups and, in particular, the chairs of the various subcommittees: Kermit Fendler, Pharm.D., W. R. "Bill" Howell, Greg Wood, P.D., Robert Theobald, Ph.D., and William Dean, R.Ph.

Much time went into planning, coordinating and staffing committee meetings and into preparing this report. The Commission would like to express its appreciation to Jane Y. Kruse, director of the Division of Medical Services. We also wish to acknowledge the important contributions made by Helen Clarkston, Marva Lubker, Susan McCann, P.D., and Doris Boeckman for their assistance to the Commission; and Connie Chadwick, Bruce Mingucci, Jayne Zemmer, Gloria Phelps and Betty Struemph for their help in staffing and coordinating the meetings of the subcommittees.

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MEMBERS
OF THE
BLUE RIBBON COMMISSION
ON
DRUG FORMULARY ASSESSMENT

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Executive Committee

James J. Mongan, M.D., Co-Chair, Truman Medical Center
Virginia Weldon, M.D., Co-Chair, Washington University
R. Keith Ayres, Mid-America Business Coalition
Richard L. Dreher, M.D., Children's Mercy Hospital
Thomas Handley, Blue Cross & Blue Shield of Kansas City
E. J. "Ned" Holland, Jr., Spencer, Fane, Britt & Browne
Gary Poff, Missouri Farm Bureau Federation
Fred Tinning, Ph.D., Kirksville College of Osteopathic Medicine

Drug Reimbursement Methodology Subcommittee

Gary Poff, Chair, Missouri Farm Bureau Federation
Fred Tinning, Ph.D., Vice-Chair, Kirksville College of Osteopathic Medicine
Mary Shaw Branton, Children's Mercy Hospital
Dianne Cleaver, M.A., Swope Parkway Comprehensive and Mental Health Center
B. David Hartwig, P.D., Red Cross Pharmacy
R. Melvin Henderson, Ph.D., William Jewell College
Larry J. McCarty, Plumbing & Pipefitters Union
George Oestreich, P.D., Dunavant Drugs
Thomas L. Sweeney, Blue Cross and Blue Shield of Missouri
Thomas C. Westfall, Ph.D., St. Louis University School of Medicine

Fiscal Impact of Formulary Expansion Subcommittee

Tom Handley, Chair, Blue Cross and Blue Shield of Kansas City
E. J. "Ned" Holland, Jr., Vice-Chair, Spencer, Fane, Britt & Browne
Geraldine Binion, Laclede Gas Company, Inc.
Mary E. "Beth" Drennen, Drennan and Associates
Bill Fitzpatrick, P.D., Fitzpatrick Pharmacy
Jon Genisio, P.D., Jon's Pharmacy
Gary Passmore, Committee to Preserve Health Care
Patsy Sampson, Stephens College
James C. Stutz, St. Louis Area Business Health Coalition
Randol M. York, SEMO Care Center, Inc.

Policy/Procedures - Formulary Additions

Richard L. Dreher, M.D., Chair, Children's Mercy Hospital
R. Keith Ayres, Vice-Chair, Mid-America Business Coalition
Ken Christgen, Jr., Walnut Products, Inc.
Erma Cunningham, Missouri Medicaid Alliance
Patricia Downs, Hellmuth, Obata & Kassabaum, Inc.
Jay Gobble, National Supermarkets, Inc.
Harvey H. Haynes, P.D., Gladstone Health-Mart
Marion Kreamer
Barry Wilkinson, Labor Counsel of Greater Kansas City
William L. "Bill" Winslow, Rider Drug, Inc.

Technical Assistance Group

Elaine Aber, Missouri Association for Social Welfare
Ken Anderson, P.D., Medicare-Glaser Corporation
Tom Beetem, Health Care Prescription Center
Eddie Mae Binion
Leslie F. Bond, M.D.
Randall Boulch, Special Health Programs
James E. Canter, D.O., Honeywell - Canter Medical Clinic
William Dean, Merrell Dow Pharmaceutical
Kermit Fendler, Pharm.D., Managed Health Care Resources
Richard Gram, Grace Hill Neighborhood Health Center
Doretta Henderson
Michael D. Hoeman, M.D.
W. R. "Bill" Howell, The Upjohn Company
Leonard Naeger, Ph.D., St. Louis College of Pharmacy
Robert W. Piepho, Ph.D., University of Missouri - Kansas City School of Pharmacy
William E. Popa, Merck Sharp & Dohme
V. L. "Ginger" Richardson, Mid-Missouri Business Health Coalition
Richard Rubison
Robert Theobald, Ph.D., Kirksville College of Osteopathic Medicine
Fred Tonnies, University of Missouri - Columbia
Valerie Walker, M.D.
Greg Wood, Missouri Pharmaceutical Association

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PART I: EXECUTIVE SUMMARY OF CONCLUSIONS AND FINDINGS

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The following statements reflect the major conclusions and findings of the Blue Ribbon Commission on Formulary Assessment. They are listed in the same sequence in which they appear in the body of the report.

The recommendations in this report fall into two types:

> Those which are narrower, short-term, and might be done administratively; and
>
> Those which are broader, long-term and require gubernatorial and legislative support for funds and changes in law.

Those in the first group are directed to the Department of Social Services and we hope they will be acted upon with diligence. Those in the second group are directed through the Department of Social Services to executive and legislative policy makers.

(1) The entire Missouri Medicaid program should undergo periodic re-examination which focuses on (1) the adequacy of coverage and funding, (2) the balance among program components, (3) the level of provider participation, and (4) the relationship of Medicaid to other existing or proposed third-party payor programs.

(2) Nearly all parts of the Medicaid program suffer from chronic underfunding. Inadequate funding is an issue which transcends all other problems, whether they be with procedures, regulations, or personnel. Adequate funding on a sustained basis is as important to this program as any other changes which must be made.

(3) The pharmaceutical component of the Missouri Medicaid program should be structured to insure appropriate therapy for patients, maximum patient access to health care, maximum provider participation, minimum fraud and abuse, and efficient use of restricted public funds.

(4) It is essential to recognize that the State does not deliver health care through the Medicaid program. Rather, it pays (partially) for care delivered by health care providers. Maintaining and encouraging provider participation in Medicaid should be one of the standards by which future policies, procedures and budgets are measured.

(5) Time and resources did not allow us to undertake necessary research to answer some of the most important questions before us and we urge the Department of Social Services to sponsor and encourage research, perhaps working jointly with Medicaid agencies in other states.

(6) The State should act as a prudent purchaser of health care services, encouraging cost savings.

(7) The State should reinvest any cost savings resulting from recently revised federal Medicaid regulations back into the Missouri Medicaid drug program. Funds should be used to (1) raise the pharmacists' dispensing fee and (2) expand the current formulary.

(8) The role and responsibilities of the Physician/Pharmacy Subcommittee should be expanded and it should have increased access to information.

(9) The Drug Utilization Review process should be reoriented from individual drug therapy to drug classes and larger patterns of appropriate (or inappropriate) drug use.

(10) Procedures should be designed to result in the lowest possible administrative/overhead costs consistent with sound fiscal management.

(11) The Medicaid formulary has an impact upon the quality of health care, patient access, provider participation, and cost to the State. In recent years, these considerations have not been balanced, with too much emphasis placed on costs. The balance should be restored.

(12) A non-restrictive formulary serves the goals of insuring appropriate drug therapy for patients and maximizing provider participation and should, therefore, be the model which the State pursues over time.

(13) Moving from a restrictive formulary to a non-restrictive formulary should be done in increments to allow sufficient time for health care providers to adapt, for State policies and procedures to be revised, for funding increments to be made available and evaluation of overall cost impact.

(14) In order to determine reasonable estimates of the statewide projected fiscal impact of expansion of the formulary and the impact of quality of care, the State should fund a pilot program to assess the impact of a non-restrictive formulary.

(15) There is a lack of public awareness and concern about Medicaid. The needs of the entire program are known only to a relatively narrow group of people in state government health care professions and patient groups.

(16) This lack of awareness had led to a lack of political commitment. Only issues perceived publicly as crises seem to gain attention of policy makers and warrant additional public funds.

(17) The Department of Social Services should work with coalitions of health care professionals, industry representatives, patient advocates and other appropriate groups to mount a public information/media campaign focusing on overall Medicaid program needs and on the magnitude and impact of declining access to health care in Missouri.

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PART II: OVERVIEW

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Many Commission members accepted this mission as an effort by the Missouri Department of Social Services to examine the needs of the Medicaid program. We did so recognizing that there are many other aspects of the program where we could have started. We believe that problems with the formulary and the pharmacy program must be viewed in the context of the larger Medicaid program. In that context, the Medicaid formulary may not be the most pressing problem, nor may it present the greatest barrier to needed health care. Rather, it is a place to start a re-examination of Medicaid.

We seek an expanded, better-funded, more "provider-friendly" Medicaid formulary. However, we know that an improved formulary does no good if a patient has no access to a physician, or to a hospital bed or to the range of other needed services.

The pharmaceutical component of the Missouri Medicaid program should be structured to insure appropriate therapy for patients, maximum patient access to health care, maximum provider participation, minimum fraud and abuse, and efficient use of restricted public funds. To insure that it serves these ends, the <u>total</u> Medicaid program should undergo periodic examination focusing on (1) the adequacy of coverage and funding, (2) the balance among program components, (3) the level of provider participation and, (4) the relationship of Medicaid to other existing or proposed third-party payer programs.

Nearly all parts of the Medicaid program suffer from chronic underfunding. Inadequate funding is an issue which transcends all other problems, whether they be with procedures, regulations, delays or personnel. Adequate funding on a sustained basis is as important to this program as anything else which must be done.

We recognize that funding problems are not recent nor restricted to Medicaid. But we know that funding has not been sufficient for six years and probably longer. It is apparent that the increases required to catch up and to <u>keep up</u> are probably too large to achieve in a single year or even two years.

What we believe is needed are (1) a public recognition that problems exist, (2) a commitment to deal with them over time and, (3) a commitment not to lose ground or fall further behind. We hope that policy-makers at all levels will thus commit themselves.

It is essential to recognize that the State does not deliver health care through the Medicaid Program. Rather, it pays (partially) for care delivered by health care providers.

Without the active support of providers, the Medicaid program is diminished and access to care for eligible patients is reduced. In some parts of our State and in some health care services, the absence of providers willing to participate in Medicaid is denying essential health care to some of our citizens. If we are to expand patient access to necessary care, maintaining and encouraging provider participation in Medicaid should be one of the standards by which future policies, procedures and budgets are measured.

In the course of our discussions we heard, and in our review of the literature we read, a number of arguments about the impact of a wide range of policies, procedures or types of formularies. Some of these arguments also conform with the perspectives, biases or beliefs of health professionals practicing in Missouri. But most of the issues before us have an impact on the health care delivered to thousands of Missourians and may take millions of dollars from a strained State treasury. Because of these consequences, we believe many of the questions raised in the course of our work deserve to be answered by more than inconclusive arguments. While we often have had to deal with arguments, opinions or beliefs, we urge the State to act as a neutral, unbiased sponsor of valid, relevant research.

Although time and resources did not allow us to undertake necessary research we urge Department of Social Services to sponsor and encourage research, perhaps working jointly with Medicaid agencies in other states.

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PART III: DRUG REIMBURSEMENT METHODOLOGY

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CONCLUSIONS:

(6) The State should act as a prudent purchaser of health care services, encouraging cost savings.

(7) The State should reinvest any cost savings resulting from recently revised federal Medicaid regulations back into the Missouri Medicaid drug program. Funds should be used to (1) raise the pharmacists' dispensing fee and (2) expand the current formulary.

(11) The Medicaid formulary has an impact upon the quality of health care, patient access, provider participation, and cost to the State. In recent years these considerations have not been balanced, with too much emphasis placed on costs. The balance should be restored.

FINDINGS:

- In complying with new federally-mandated aggregate limits on state spending for multiple-source drugs, the Division of Medical Services should recognize the need for a reasonable return to pharmacists if they are to continue to participate in the Medicaid program.

- Specifically, funds saved by implementing the new regulation should be used to increase the pharmacy dispensing fee to at least those levels proposed in previous Division of Medical Services budgets.

- For fairness and efficient use of program funding, the Division of Medical Services should identify all multiple-source drugs on the Missouri Medicaid formulary which are in addition to those identified by the Federal government, establish appropriate reimbursement levels, and adjust prices as necessary.

- For single-source drugs, the competitive marketplace is probably the most reliable and appropriate indicator of retail price and the State should consider adopting a "usual and customary charges" model of reimbursement for them.

- The State should continue its efforts to encourage substitution of generic drugs for name-brand drugs,

-- by increasing the education of health care professionals on the use of generics, and

-- by revising the existing prescription form and requiring physicians to note in their own handwriting "dispense as written" to indicate that the trade name product must be dispensed. Such a revision would require a statutory change.

- One of the goals of Medicaid should be to maximize patient access and the copayment should not be a barrier to needed drug therapy. The State should undertake research to determine the impact of the present copayment on utilization, patient access, and provider participation. If such research reveals that the copay is ineffective or creates a barrier to access, it should be eliminated or revised.

- The State should examine the feasibility of entering into rebate agreements directly with pharmaceutical manufacturers, and should consider enactment of legislation which would allow refunds from rebate discounts to be earmarked revenues dedicated to the expansion of the Medicaid formulary rather than reverting to the General Revenue Fund.

BACKGROUND:

The objective of the Drug Reimbursement Subcommittee was (1) to conduct a comprehensive review of alternative reimbursement methodologies for prescription drugs and (2) to formulate recommendations to the Department of Social Services for a Medicaid reimbursement methodology which provides access to quality care, a fair price to providers and maximizes the use of public dollars.

The subcommittee was divided into three groups and each group met and studied specific issues related to:

- Cost sharing and multiple source drugs;
- Acquisition cost and dispensing fee reimbursement; and
- Alternative cost containment options, bulk purchase and manufacturers' rebates.

Staff of the Division of Medical Services made reports to the Subcommittee on how the pharmacy program works from the time a recipient goes to the doctor to obtain a prescription through the time the claim is processed. The presentation included a prescription form, the pharmacy claim form, a pharmacy remittance advice, a turn-around claim (TAC) and a flow chart showing the process of obtaining a prescription through adjudication of a Medicaid pharmacy claim. There was a second staff presentation on drug reimbursement explaining that

manufacturers price drugs differently depending on the purchaser; institutions may pay one price for a drug, wholesalers may pay a different price for the same drug and pharmacies may pay yet another price. This results in a problem determining the actual acquisition cost because there are many different price lists depending upon who the purchaser is.

Staff reported that, at the request of the federal government, the Medicaid agency initiated a study to determine estimated acquisition costs (EAC). The survey instrument was developed by a group of pharmaceutical providers and sent to a randomly selected group of pharmacies. A 10% sample of the results was audited to validate the accuracy of the survey.

Staff also gave a brief overview of the federal regulation implementing the Pharmacist's Incentive Program effective in October 1987. They indicated this final rule identified certain brand name drugs that are multiple source drugs for which reimbursement will be set at 150% of the least costly therapeutic equivalent. The limit is an aggregate upper limit test so the State must be able to demonstrate to the federal government that total reimbursement does not exceed the ceiling. Under the new rule, the dispensing fee is in addition to reimbursement for the drug ingredient cost.

The Subcommittee reviewed a number of documents comparing various state reimbursement levels and methodologies, including dispensing fees, co-payments and basis for ingredient reimbursement. Data showing how states allocate Medicaid dollars, how they compare an average expenditure per recipient, and how they rank in recipient and expenditure levels were studied. An analysis of cost factors in marketing Medicaid drugs was also received.

The group studying cost-sharing and multiple-source drugs felt that they did not have enough solid information to make recommendations and suggested that the State collect information on the following:

1) Number of recipients who failed to obtain a prescription because of the copay requirement;
2) Amount collected by pharmacists through the co-pay system;
3) Percent of non-exempt recipients who actually make the copayment;
4) How HMOs and PPOs across the state handle cost sharing; and
5) What other states mandate a copay and what are their percentages of collection.

In reference to multi-source drugs, the committee made several recommendations in light of the adoption by HCFA of the Pharmacist's Incentive Program (PhIP). They suggested that the State provide training and education for pharmacists,

physicians, and Medicaid recipients on multi-source drugs; and provide physicians with a Medicaid formulary listing by therapeutic class, which includes prices. They proposed that the State contact Connecticut and Pennsylvania with regard to their generic incentive programs to determine if there are any problems or benefits to the program and solicit proposals from the Missouri Pharmaceutical Association and other appropriate organizations on the alternative incentive programs to compare with the PhIP.

The group studying alternative cost containment options considered a variety of alternatives, including (1) having the State act as a warehouse and distribution center for drugs; (2) letting the State act on behalf of pharmacies across the state to enter into a prime vendor agreement, whereby a large volume of drugs could be purchased at a discount price; (3) entering into a rebate agreement for any volume of a particular manufacturer's drug which could be tracked by the name brand of the drug; and (4) letting pharmacies negotiate their own discount and rebate arrangements.

The group on drug acquisition cost and dispensing reviewed staff materials, the new federal regulation and the overall average discount received by providers as reflected in the estimated acquisition cost survey. They proposed adoption of the usual and customary model of reimbursement with some degree of discount, some generic incentive, the best buying conditions for the State, and the best accessibility for the recipient.

The Subcommittee also considered ways for monitoring fraud and abuse, policies to increase incentives for use of generics, and problems with copayment requirements.

During the deliberations on reimbursement, the Health Care Financing Administration (HCFA) finalized a previously proposed federal regulation which significantly impacted upon Medicaid reimbursement for drugs. This final regulation was published in the Federal Register on July 31, 1987, and took effect on October 29, 1987. It required that the Commission reassess its proposals regarding drug reimbursement methodologies.

The intent of the federal regulation was to establish aggregate limits on State spending for certain multiple source drugs. The federal regulation says that the states' payments for identified multiple-source drugs "must not exceed, in the aggregate, payment levels determined by applying for each drug entity a reasonable dispensing fee established by the agency plus an amount established by HCFA that is equal to 150% of the published price for the least costly therapeutic equivalent...."

HCFA established upper payment limits for multiple source drugs for which all formulations of the drug were approved by the Food and Drug Administration and evaluated as therapeutically equivalent.

Working Papers

The following documents were developed or reviewed by members of the Subcommittee on Drug Reimbursement methodology in the course of their deliberations. They are available, as backup to this report, from the Missouri Division of Medical Services.

Health Care Financing Administration. "State Agency Comments on the Competitive Incentive Program", August 1986.

Missouri Division of Medical Services. "Issue Paper on Drug Reimbursement", July 1987.

Missouri Division of Medical Services. "Missouri Medicaid Pharmacy Program - Transactions From Service Delivery to Claim Disposition", July 1987.

Missouri Division of Medical Services. "Missouri Medicaid Pharmacy Program - Usual and Customary Charge Telephone Survey", September 1987.

Missouri Division of Medical Services. "Projected Administrative Costs Associated With Usual and Customary Reimbursement", September 1987.

Oestreich, George and Fred Tinning. "Potential Method of Medicaid Billing For Prescription Drugs at Usual and Customary Charges", August 1987.

Simmons, Susan A. "Marketing Medicaid Drugs: An analysis of Cost Factors" in Journal of Health Care Marketing, September 1986.

Wood, Greg. "Memorandum to Subcommittee from Greg Wood, Missouri Pharmaceutical Association", July 1987.

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PART IV: POLICY AND PROCEDURES

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CONCLUSIONS:

(8) The role and responsibilities of the Physician/Pharmacy Subcommittee should be expanded and it should have access to increased information.

(9) The Drug Utilization Review process should be re-oriented from individual drug therapy to drug classes and larger patterns of appropriate (or inappropriate) drug use.

(10) Procedures should be designed to result in the lowest possible administrative/overhead costs consistent with sound fiscal management.

FINDINGS:

- The role, responsibilities and procedures of the Physician/Pharmacy Subcommittee should be revised in the following ways:

  The Physician/Pharmacy Subcommittee should not be limited to adding drugs to the formulary only after application by a manufacturer. The Subcommittee should conduct a regular (at least once in three years) systematic review of each drug class. Results of the review should lead to additions to the formulary.

  The Physician/Pharmacy Subcommittee should have access to and review a quarterly summary of drug exception cases. The Subcommittee should add drugs to the formulary which are widely requested but not available.

  Cost and utilization reports resulting from the Drug Utilization Review process should be provided to the Physician/Pharmacy Subcommittee on a regular basis.

  Actions of the Physician/Pharmacy Subcommittee should be taken by closed ballot to insure that members vote freely without pressure from peers, Division of Medical Services staff or pharmaceutical manufacturers.

- Maximum Allowable Cost procedures should be revised in the following ways:

  Drugs should be reviewed for MAC pricing immediately after going off patent.

  Before a new MAC price is implemented, pricing information should be published in the Missouri Register to allow time for comment.

- The Division of Medical Services should develop and propose and the Physician/Pharmacy Subcommittee should review and approve a deletion process with priorities for therapeutic classes which would be used in a time of fiscal crisis to reduce existing spending levels in the Medicaid pharmacy program. Once prepared and approved, such process and listing should be reviewed for currency.

- Individual drug therapy reviews are believed to be largely ineffective. The Drug Utilization Review Process should, instead, focus on larger patterns of inappropriate drug use; and, as soon as it is added to the formulary, utilization of a drug should be tracked.

- Drug Utilization Review should focus on classes of drugs and be correlated with utilization of related drug classes whose use might be altered by changes in the class being tracked.

BACKGROUND:

The objective of the Policy and Procedures Subcommittee was to offer guidelines for improving pharmaceutical care through proper monitoring of expenditures.

The Subcommittee held four meetings and heard testimony from members and the technical advisory group. Discussions focused on the utilization review process and patterns of prescribing, as well as issues of reimbursement and formulary revisions. Discussion on the latter topics were referred to other subcommittees studying these issues.

The role, workload and procedures of the Physician/Pharmacy Subcommittee were reviewed in detail. The Subcommittee discussed and adopted specific policy statements on the formulary and DUR process, as follows:

"Formulary additions/deletions should be reviewed with a goal of improving patient care while recognizing limited resources and controlling cost."

"Establish and maintain a system of data processing, drug therapy evaluation and policy initiatives designed to optimize drug therapies and minimize unnecessary expenditures."

There was extensive discussion about the value and timing of individual drug regimen review (DRR).

The chairman of the Policy and Procedures Subcommittee appointed two subgroups to study the following areas:

- Formulary additions/deletions; and
- Drug Utilization Review process.

The subgroups completed their work and recommendations were presented to the subcommittee. The basic proposals were divided into short-term and long-term goals. Short-term goals included improvements to the formulary revision methodology and changes in the exception process. Long-term goals identified by the Subcommittee included improving the quality of pharmaceutical care through expanded review, controlling expenditures through the utilization review process, and saving funds through reduction in administrative overhead.

On the issue of drug additions, the Subcommittee recommended that the basic methodology be held intact, but suggested some changes.

One area of concern raised by the Subcommittee was the voting process used by the Physician/Pharmacy Subcommittee for drug additions. They suggested a closed method of voting following the drug manufacturer's presentation. The meetings would remain open to the public, and the final selection of drugs should be circulated publicly. Analysis of the state public meeting law should be done to determine whether such changes would be consistent with the "sunshine" provision of the law.

The Subcommittee also recognized that the drug addition process goes hand-in-hand with the Utilization Review Process. Drug utilization should be tracked after a drug is added to the formulary and utilization of all drugs within a class should be tracked with other drug classes whose utilization could be potentially altered by the drug addition. This would reveal any inappropriate utilization of the new drug, or changes in overall utilization of the other affected drugs.

The Subcommittee concluded that a regular agenda item for the quarterly Physician/Pharmacy Subcommittee meetings should be the review of drug exception cases for the past quarter. This report should be produced by the Recipient Services Unit in the format used for the special report, "Summary of Drug Requests Through the Exception Process for FY-1987," which was produced for the Blue Ribbon Commission. The Physician/Pharmacy Subcommittee members should be able to regularly review widely

requested drugs which are not available on the formulary. Determinations could then be made to add drugs which are deemed appropriate for access without prior authorization.

On drug additions, the Subcommittee further concluded that the Physician/Pharmacy Subcommittee should not be solely reliant on the application process for the addition of drugs to the formulary. A regular and systematic review of each therapeutic drug class would reveal areas of need on the formulary. This review would not be limited to the presently covered drug classes. Potential additions should be prioritized according to the severity of the illness which the drug treats (for example, adding drugs for cardiac conditions before drugs for allergies). Drugs appropriate for addition should be referred to the drug manufacturers for fiscal calculations. Also the state could supply the data when a manufacturer opted not to apply for a drug.

The Subcommittee believed all drug classes should be reviewed after a three year period. This was considered to be essential to assessing the drug needs of Missouri Medicaid patients.

The Subcommittee concluded that there needs to be routine identification of inappropriately utilized drugs through the Drug Utilization Review process. Inappropriately utilized drugs should be reported to the Physician/Pharmacy Subcommittee for their review and appropriate action. Further, the Subcommittee recognized that a deletion process for times of fiscal crisis is needed. It suggested that the Physician/Pharmacy Subcommittee rank the therapeutic classes of drugs according to the severity of illness which the class of groups is used to treat. Classes which treat the less severe illnesses should be scrutinized for transferring coverage to the exception process.

With respect to the drug exception process, the subcommittee suggested a mechanism to allow for pilot projects which would give direct access to non-covered drugs. Strict auditing should allow for immediate cessation of the pilot if large scale abuse occurs. A pilot project was suggested to provide direct access to morphine for eligible oncology patients.

For cost-containment purposes, the Subcommittee proposed that drugs be reviewed for possible MAC pricing immediately after going off patent, rather than waiting the current two-year period with the Orange Book used as the reference for this information. Prior to implementing a new MAC, pricing information should be published in the Missouri Register, to allow time for public comments with regard to statewide accessability at the MAC price. The current MAC pricing procedure should otherwise be continued unchanged.

On drug utilization review, the Subcommittee proposed that the process be changed from its current focus on individual drug therapy to over-all patterns of inappropriate drug use.

Individual drug therapy reviews were found to have little impact on patient care and not to be cost-effective. The Subcommittee felt that a focus on high volume, high cost drugs would serve to more effectively reduce inappropriate utilization and improve quality of care.

Prospective education was considered an important aspect of a reformed DUR system and the Subcommittee suggested that educational articles originating from a school of pharmacy be circulated through the professional association journals or newsletters on a regular basis. The articles should emphasize quality of care, and should include information regarding the fiscal restrictions of the Medicaid Program.

A new DUR system should also allow for identification of specific patient regimens (as well as exceptional providers) as a secondary review process. Cost and utilization reports should be referred to the Physician/Pharmacy Subcommittee as supporting documentation to back DUR recommendations for retaining or deleting drugs.

Finally, it was suggested that a study be performed at some future date to quantify cost-savings resulting from the change in the drug utilization review process.

The Policy and Procedures Subcommittee recommended that ambulatory recipients have access to the same drug monitoring services available to long-term care patients. The Subcommittee recommended that this responsibility be given to the dispensing pharmacy. To encourage monitoring, members suggested an additional fee be offered to the pharmacy for maintaining a patient profile and for monitoring patient drug use. Documentation by the pharmacy to substantiate the provision of this service would also be required.

The Subcommittee observed that a more effective and thorough DRR could be accomplished by asking the recipient to choose a single pharmacy provider for exclusive service during a given period of time.

One incentive for a recipient to do this might be to offer coverage of over-the-counter drugs through the providing pharmacy chosen. This would allow greater access to drugs for the recipient and afford a more complete DRR by the dispensing pharmacist. Under such a system, the choice to use a single pharmacy should be strictly voluntary. Over-the-counter drugs which might be available without prescription could be restricted to certain categories, such as cough/cold preparations, antacids, topicals, etc. The Subcommittee suggested a study be undertaken to identify any cost-savings which might result from implementation of the suggested DRR process.

Working Papers

The following documents were developed or reviewed by members of the Subcommittee on Policy and Procedures in the course of their deliberations. They are available, as backup to this report, from the Missouri Division of Medical Services.

Blue Ribbon Commission on Drug Formulary Assessment. "Telephone Survey of Other States", July 1987.

Division of Medical Services Staff. "Policy/Procedures Background Paper", July 1987.

Dreher, Richard, M.D. and Keith Ayres. "Memorandum to Dr. Weldon and Dr. Mongan", October 1987.

DUR Task Force. "Memorandum to Dr. Richard Dreher", August 6, 1987.

Missouri Division of Medical Services. "Summary of Drug Requests Through the Exception Process for FY 1987", July 21, 1987.

National Association of Boards of Pharmacy Newsletter. "FDA Speaks Out About Generic Drug Quality", April 1986.

NPC. "Summary of Drug Programs for eleven (11) states", NPC 1986.

Zaenger, Allan F. R.Ph., M.S. "Iowa Drug Utilization Review", June 1987.

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PART V: FISCAL IMPACT OF FORMULARY EXPANSION

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CONCLUSIONS:

(12) A non-restrictive formulary serves the goals of insuring appropriate drug therapy for patients and maximizing provider participation and should, therefore, be the model which the State pursues over time.

(13) Moving from a restrictive formulary to a non-restrictive formulary should be done in increments to allow sufficient time for health care providers to adapt, for State policies and procedures to be revised, for funding increments to be made available and evaluation of overall cost impact.

(14) In order to determine reasonable estimates of the statewide projected fiscal impact of expansion of the formulary and the impact on quality of care, the State should fund a pilot program to assess the impact of a non-restrictive formulary.

FINDINGS:

- Analysis of Medicaid formularies in other states does not provide appropriate or sufficient guidance on the total fiscal impact of changing Missouri's formulary from very restrictive to non-restrictive or to some intermediate less restrictive level.

- Overall health care costs for any given patient might be reduced by expanded drug therapy, but such cost savings will not likely reduce budgetary requirements for other components of the Medicaid program.

- Some health care provider associations support a non-restrictive formulary because it would create fewer limits on members' practices and require less administrative time and expense.

- A non-restrictive formulary should cost less to administer, although, as above, budgetary savings might not result.

- A non-restrictive formulary should minimize the need for physicians to adjust treatment patterns for patients based on their economic circumstances. Further, better patient compliance may result from an expanded formulary which offers different modalities and dosages.

- A non-restrictive formulary should reduce inefficient or inappropriate alternative treatment methods which circumvent current formulary restrictions.

- Easing the restrictions on the existing formulary should be done in increments, as follows:

  Phase I: The Physician/Pharmacy Subcommittee should immediately consider the selective inclusion of certain therapeutic drug classes and any changes in operating procedures that improve the function of the committee.

  Close monthly monitoring of drug utilization patterns should accompany the inclusion of all therapeutic classes.

  A pilot study to test the full implementation of a non-restrictive formulary and its impact on the cost and quality of pharmaceutical services should be undertaken by the State. This study should be designed to determine the desirability of fully adopting a non-restrictive formulary in Phase IV.

  Phase II: Selective inclusion of injectable dosage forms of covered drugs used most frequently by nursing home patients.

  Phase III: Expand coverage to include other therapeutic class of drugs.

  Phase IV: Continued easing of restrictions based on exception reviews, DUR's and review of the first three phases.

  Addition of any therapeutic class for a life-threatening or serious illness should take precedence over the above increments. AZT would be an example of such an addition.

- The Division of Medical Services should have the flexibility to recommend supplemental or emergency appropriations or changes among appropriations from one fiscal year to the next.

BACKGROUND:

The objective of the Fiscal Impact of Formulary Expansion Subcommittee was to formulate recommendations to the Department of Social Services for a Medicaid drug formulary which would provide optimum medical care to Missouri's public assistance recipients. In order to achieve this objective, the

Subcommittee set out to conduct a comprehensive review of data available regarding the use of non-restrictive or restrictive formularies. They sought to estimate the fiscal impact of providing these services and formulate recommendations for implementation and for funding of recommended policy changes.

Staff provided the Subcommittee with a number of surveys and summaries of Medicaid pharmacy programs around the county. These compared levels of patient participations overall benefits available to recipients, and exclusions or limitations on prescribed drugs and costs. The Subcommittee also reviewed changes made in the state Medicaid program in recent years. These reports included summaries of new utilization controls, cost containment measures, and new management approaches.

The Subcommittee requested that additional information comparing formularies and program costs be developed. A telephone survey was conducted to collect data from eleven states somewhat camparable to Missouri in geography, size, and demography. States were surveyed on the degree to which their formulary is restrictive, whether the restrictions have an impact on patient care, whether they have a financial impact, what exclusions are in effect, and how recent costs and utilization have changes.

As a further measure to compare states, the Subcommittee attempted analysis of payments, recipients and projected costs for eight states with less restrictive formularies and five states with restricted formularies (including Missouri). States were selected with reimbursement methods and formulae similar to Missouri's and with geographic and demographic characteristics similar to Missouri's. The study compared only the average of the selected restrictive and non-restrictive states. The study also compared the costs of other services per Medicaid eligible for both restrictive and non-restrictive formulary states.

After review of the various reports and survey data, members recognized that analysis of Medicaid formularies in other states does not provide sufficient specific guidance on the impact of changes to Missouri's program. States vary in recipient eligibility requirements, cost containment policies and procedures, and service utilization to such a degree that some with open formularies spend no more than some with restricted formularies while others spend considerably more.

In practice, formularies are structured differently in different states. Some states may exclude all over-the-counter preparations and supplies and include all legend products. Other states may include all over-the-counter preparations but exclude certain therapeutic classes and injectables. In addition, states with restricted formularies are generally forced to establish an exception process in order to make non-covered drugs and medical supplies available when these are deemed to be necessary for specific individuals.

The technical advisory group sought input from providers and conducted an informal survey of physicians, pharmacists and dentists in northeast Missouri. Respondents were asked to identify practice problems caused by the formulary, changes desired in the formulary and exception process, and drugs which should be added to the formulary. Only 15 providers familiar with Medicaid responded. Most felt that the formulary should be less restrictive and identified problems which current restrictions create for physicians.

The technical advisory group prepared a discussion paper summarizing argument for a non-restrictive formulary. It cited claims that a non-restrictive formulary could lead to cost savings by allowing later hospital entry, increased outpatient procedures and less surgery. Similar savings might occur in use of long-term care programs. It also suggested that costs of administering a restrictive formulary could be reduced. There was considerable discussion over these issues and whether such theoretical savings would produce real budgetary reductions.

The technical advisory group also suggested that very restrictive formularies may create problems for patient care and provider participation in Medicaid programs. The group further concluded that a restrictive formulary may not control overutilization of drugs.

Members of the Subcommittee reported that many of the claims for or against open formularies came from studies which might be biased or inconclusive. After much discussion, the Subcommittee recommended that the State adopt a non-restrictive Medicaid formulary including all legend and non-legend drugs with restrictions on certain therapeutic classes of drugs appropriate if properly evaluated by the Physician/Pharmacy Subcommittee. It further recommended that Division of Medical Services generate a quarterly report on drugs requested through the exceptions process. This report should include, but not be limited to, the frequency and types of drugs being requested by the providers. The quarterly report should be reviewed by the Physician/Pharmacy Subcommittee and the Medical Advisory Committee.

The Subcommittee also proposed that the Division of Medical Services have additional limited flexibility in fiscal management of the Medicaid program and continue to refine and implement cost savings approaches, such as setting a maximum allowable cost on drugs which would lower the cost of drugs to the State, utilization review, and other monitoring programs.

The Subcommittee also adopted a multi-year plan for transition to a less-restrictive formulary, as follows:

> **Phase I:** The Physician/Pharmacy Subcommittee should immediately consider the selective

inclusion of certain therapeutic drug classes and any changes in operating procedures that improve the function of the committee.

Close monthly monitoring of drug utilization patterns should accompany the inclusion of all therapeutic classes.

A pilot study to test the full implementation of a non-restrictive formulary and its impact on the cost and quality of pharmaceutical services should be undertaken by the State. This study should be designed to determine the desirability of fully adopting a non-restrictive formulary in Phase IV and the cost impact on the drug and non-drug components of the Medicaid program. The study should be initiated during Phase I with the results to be continually monitored as subsequent phases are initiated.

Phase II: Selective inclusion of injectable dosage forms of covered drugs used most frequently by nursing home patients.

Phase III: Expand coverage to include other therapeutic class of drugs.

Phase IV: Continued easing of restrictions based on exception reviews, DUR's and review of the first three phases.

Addition of any therapeutic class for a life-threatening or serious illness should take precedence over the above increments. AZT would be an example of such an addition.

The Subcommittee chose only a limited number of therapeutic classes for early inclusion in the expansion. Priority was given to those drugs necessary to immediately improve the clinical adequacy of the formulary. The classes chosen were decided upon after a review and analysis of several source documents:

1) Drugs most frequently requested through the exception process;

2) The current Missouri Medicaid formulary, and

3) A listing of drugs covered by a sample of comparable states.

Recommendations for the expansion cover four phases in order to assure that adequate data are collected and analyzed to determine how various aspects of the expansion program are working.

Working Papers

The following documents were developed or reviewed by members of the Subcommittee on Fiscal Impact of Formulary Expansion in the course of their deliberations. They are available, as backup to their report, from the Missouri Division of Medical Services.

Binion, Geri, etal. "How to Expand the Formulary", August 1987.

Drennan, Beth. "A Process For Implementing Recommendations", September 1987.

Handley, Tom. "Assumptions Used to Develop Fiscal Estimates", September 1987.

Howell, Bill and Robert Theobald, Jr. "Justification For Formulary Expansion", August 1987.

Missouri Division of Medical Services. "Open Versus Restricted Formularies - Background", July 1987.

Missouri Division of Medical Services. "Telephone Survey of Eleven States' Medicaid Program - Summary", July 1987.

National Governor's Association Memorandum. "Catalog of State Medicaid Program Changes", May 1986.

National Pharmaceutical Association (excerpts). "Pharmaceutical Benefits Under State Medicaid Assistance Programs - 1986", 1986.

Theobald, Robert, Jr. "Provider Survey of Current Medicaid Drug Formulary - Summary", August 1987.

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PART VI: STRATEGIES FOR IMPLEMENTATION

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CONCLUSIONS:

(15) There is a lack of public awareness and concern about Medicaid. The needs of the entire program are known only to a relatively narrow group of people in state government, health care professions, and patient groups.

(16) This lack of awareness has led to a lack of political commitment. Only issues perceived publicly as crises seem to gain attention of policy makers and warrant additional public funds.

(17) The Department of Social Services should work with coalitions of health care professionals, industry representatives, patient advocates and other appropriate groups to mount a public information/media campaign focusing on overall Medicaid program needs and on the magnitude and impact of declining access to health care in Missouri.

BACKGROUND:

The needs and problems of the pharmacy program -- as with most of the component programs of Medicaid -- are known to a relatively narrow group of people in State government, the health care professions, and the pharmaceutical industry. Real problems of patient access, inappropriate care, and declining provider participation are not yet major issues widely viewed as justifying major policy changes or additional revenues.

In the current political climate, however, only those issues which present themselves as crises seem to gain the needed attention of policymakers or justify additional public funds. Without proper groundwork leading to heightened public awareness and firm political commitment, we are concerned that the needs and problems of the Missouri Medicaid program have little chance of being corrected.

Over the long term, the Department of Social Services should work with coalitions of health care professionals, industry representatives, patient advocates and other appropriate groups to mount a public information/media campaign to focus on Medicaid program needs and on the magnitude and impact of declining access to health care in Missouri.

The Department of Social Services should establish other "Blue Ribbon Commissions" to investigate problems of the Medicaid system. The reports of such commissions should be

integrated to provide the basis for in-depth evaluation and overview of the Medicaid program, and should lead to long-range goals for its improvement.

The Formulary Expansion Subcommittee addressed the issues of implementation and recognized several major obstacles. In addition to the lack of public awareness and political commitment, they noted inadequate state revenues to finance necessary improvements and intense competition among health care providers for available revenues. They were further concerned about a lack of meaningful evaluation of the entire Medicaid program or a long range plan for Medicaid system improvements.

They proposed a multi-year strategy to address these problems which they hoped would lead to an expanded state budget for formulary expansion for FY 1989 and beyond. The primary objectives of the multi-year strategy are:

- To inform and educate the general public and legislature by means of an aggressive media and public information campaign.
- To organize a support network of health care professionals, industry representatives, patient advocates and other appropriate groups.
- To frame the issue of formulary expansion in the context of the larger Medicaid program and its problems.
- To document, through research and statistics, the validity and costs of the non-restrictive formulary for Missouri.

They recommended the following steps be taken by the Department of Social Services to obtain these strategy objectives.

1. The budget request of the Department of Social Services should include funding for the dispensing fee increase and for additions to the Medicaid formulary of high priority drugs.
2. The final report of the Blue Ribbon Commission should be released to Governor Ashcroft and to legislative leaders prior to its release to the press. The chairpersons and Commission members should formally present the report and the Department should be prepared to respond to the recommendations. A special press event should be planned.
3. The Department should present Commission findings to health care providers, patient advocates and other interested groups and should solicit their comments and endorsements.

4. The Department should enlist health care professionals, patient advocates and industry representatives to undertake a public information campaign focusing on the magnitude of the problem and how it effects the whole of society and health care in particular. Some important elements of this effort should be:

   - To prepare background information which would translate complex issues and professional jargon into issues and messages appropriate for the mass media.

   - To inform and train a team of articulate spokespeople for each media market.

   - To organize and conduct visits to newspaper editorial boards.

   - To prepare talks with visual aids for civic/business organizations and for use in the electronic media.

   - To translate statewide problem and solutions to the level of individual communities and illustrate them with local examples.

   - In the upcoming election year, to use candidate forums to raise the problem and proposed solutions.

5. The Department of Social Services should utilize other available legislative forums (such as the Joint Interim Committee on Missouri Medical Systems) to promote a non-restrictive Medicaid formulary and other Medicaid improvements.

6. The Department of Social Services should request funding for the continued phase-in of the non-restrictive formulary for FY 1990, FY 1991 and FY 1992 so the by FY 1992 all drugs except those specifically excluded by the Medicaid Advisory Committee shall be included in the Formulary. In addition, for FY 1990, the Department should request funding for a pilot program to evaluate costs of a non-restrictive formulary for budget planning purposes.

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VII. APPENDICES

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RESOURCES:

Curtis, Richard and Ian Hill. "Affording Access to Quality Care: Strategies for State Medicaid Cost Management". Washington, D.C.: The National Governor's Association, July, 1986.

Maggard, H. F. "Medicaid Eligibility: New State Options". Washington, D.C.: National Conference of State Legislators, February, 1987.

Missouri Department of Social Services. "Monthly Administrative Analysis, Table 5, Medicaid Statistics".

Missouri Division of Medical Services. "Standard Data Set".

Missouri Department of Social Services, "A Policy Analysis Model" 1987.

National Pharmaceutical Council, Inc., "Pharmacy Benefits Under the State Medical Assistance Programs", September 1987.

Yondorf, B., N. H. Shanks and Robert Pierce. "Hospital Cost Containment: A Legislator's Guide". Washington, D.C.: National Conference of State Legislatures, May, 1985.

OVERVIEW
MISSOURI MEDICAID PROGRAM

The Medicaid Program, authorized by federal legislation in 1965, provides low income persons who are age 65 or over, blind, disabled or members of families with dependent children access to health care. The Program is jointly financed by the federal and state governments and administered by the states. In Missouri, the Medicaid Program is administered by the Division of Medical Services, a division within the Department of Social Services.

Missouri's commitment to providing health care for the indigent predates the federal enabling legislation. In 1959, a limited medical assistance program was begun. Coverage was limited to inpatient hospital care with a maximum reimbursement rate of $5.00 per day, with benefits limited to 100 days per patient per year. In 1963, due to opportunities afforded by federal law, Missouri implemented limited prescription drug and dental programs for the adult assistance categories as they were the only programs for which federal funds could be claimed.

In October 1967, the 74th Missouri General Assembly enacted legislation establishing a medical services program under provision of Title XIX of the Social Security Act, to be known as the Medicaid Program. When Missouri's Title XIX, or "Medicaid" Program was implemented, the new services covered by the program included outpatient hospital care, physicians' services, professional nursing home care, and x-ray and laboratory services. In addition to expansion of services, coverage was extended to other assistance categories, thus providing first time coverage to the blind, permanently and totally disabled recipients, and greatly expanding services to Aid to Families with Dependent Children. The amount appropriated for the program in State FY-68 was $19.4 million.

The State also has a limited medical assistance program which is funded with State General Revenue and Blind Pension funds. The program allows General Relief, Child Welfare Services (CWS), and Blind Pension recipients who are not eligible for the federal Medicaid Program to receive necessary medical care.

Administration

In the State of Missouri, the Department of Social Services (DSS), is officially designated as the agency charged with administration of the state's medical assistance and the federal Medicaid (Title XIX) programs.

Claims for medical services are processed by a fiscal agent. The fiscal agent is selected through a competitive bid process. The fiscal agent operates a computerized system of

claims processing using claims data, provider and client eligibility data and an extensive system of edits and audits.

Claims are adjudicated by the fiscal agent to a pay or deny status and the provider notified by a remittance advice. The provider is issued a check by the State of Missouri.

Eligibility

A recipient must apply for public assistance at the county Division of Family Services office in which (s)he resides. The county caseworker takes an application and, based on the information received, makes an eligibility determination. If the recipient is determined to be eligible, the individual or family receives a Medicaid identification card or an approval letter from the Division of Family Services' County Office which is valid for a period of one month. The recipient must present this card or a letter to a provider of services each time a medical service is rendered. The recipient is issued a new identification card for each month that (s)he continues to be eligible for Medicaid benefits.

In Missouri, there are approximately 313,000 persons eligible to receive Medicaid services in any given month with more than one-half of the eligibles actually utilizing services monthly.

Eligibles fall within the following types of assistance:

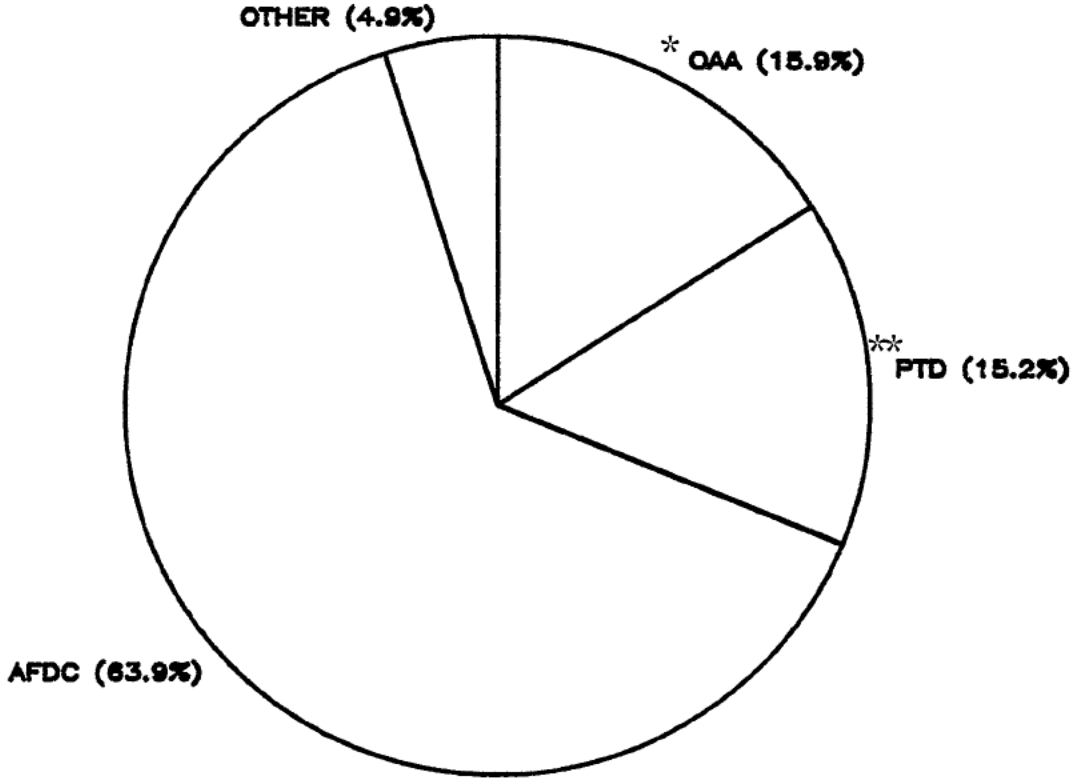
Federal/State Funded Types of Assistance	State Only Funded Types of Assistance
AFDC - Aid to Families with Dependent Children	BP - Blind Pension
MA - Medical Assistance	GR - General Relief
MA-OAA - Medical Assistance-Old Age Assistance	CWS - Foster Care
MA-PTD - Medical Assistance-Permanently and Totally Disabled	SP - Supplemental Payment (to SSI conversions)
AB - Aid to the Blind	
NC - Nursing Care	
PC-22 - Psychiatric Care under 22 years	
ADC-FC - Foster Care	
GR-UB - General Relief - Unborn	
REFUGEE - Refugee	
HDN - Homeless, Dependent, Neglected Children	

As a result of legislation passed by the 84th Missouri General Assembly and signed into law by Governor Ashcroft, a new group of low income persons became eligible for Medicaid effective January 1, 1988. Medicaid will expand coverage to pregnant women and children up to age two years whose income

does not exceed 100% of the federal poverty level and who meet certain resource requirements.

The chart below illustrates the breakdown of all eligibles by major eligibility groups during FY-87. The AFDC population comprises 64% of all eligibles, while OAA and PTD are approximately 15% each.

MEDICAL ASSISTANCE ELIGIBLES YTD 1987

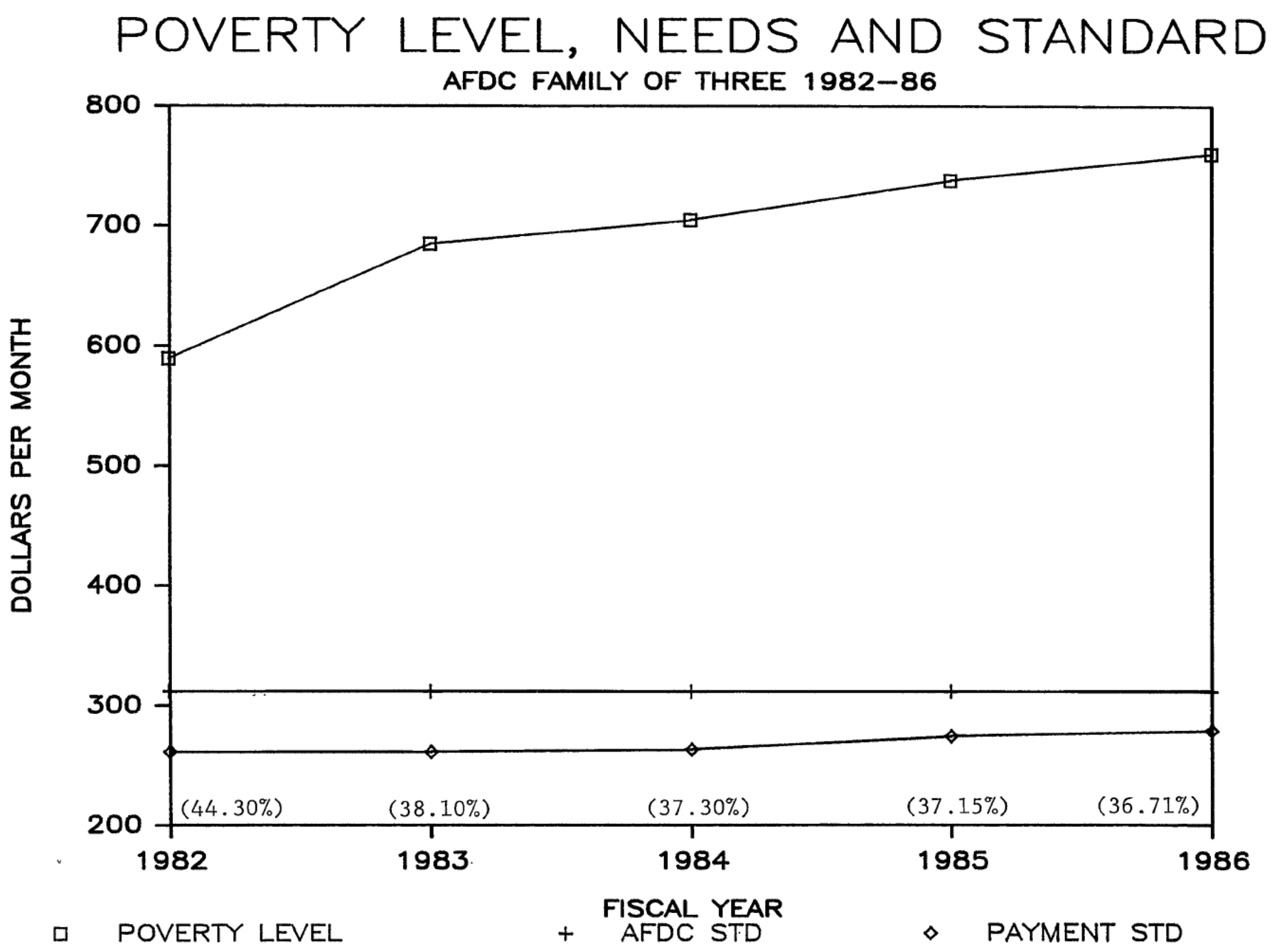


* Medical assistance eligible due to age
** Medical assistance eligible due to disability

AFDC, although currently the largest assistance group, accounts for only 20% of all expenditures. In contrast, about 20% of all recipients are over the age of 65, and account for approximately 50% of all expenditures.

Poverty Level Needs and Standards

The following table shows a comparison of the federal poverty level to the Missouri AFDC need standard and payment standard. The AFDC need standard is the dollar amount which the State has established as representing all expenses for an average person or family to live in a manner compatible with decency and health. The payment standard, which is based on available appropriations, is 89.54% of the AFDC need standard and represents the maximum grant amount for a particular family size. The need standards must be met in order to qualify for assistance.


POVERTY LEVEL, NEEDS AND STANDARD
AFDC FAMILY OF THREE 1982–86
800
700
600
500
400
300
200
DOLLARS PER MONTH
(44.30%)
(38.10%)
(37.30%)
(37.15%)
(36.71%)
1982
1983
1984
1985
1986
FISCAL YEAR
POVERTY LEVEL
AFDC STD
PAYMENT STD

In 1986, the monthly payment standard for an AFDC family of three was $279 compared to the federal poverty level of $760. The payment standard was 36.70% of the federal poverty level, or rather, a family of three had to be at 36.7% of poverty or below to qualify for assistance. From 1982 to 1986 the payment standard as a percent of the federal poverty level has decreased from 44.30% to 36.7%.

Comparison
Poverty Level to AFDC Need Standard
and Payment Standard

	Monthly Amount for (Family of Three)				
	1982	1983	1984	1985	1986
Poverty level	589.17	685.00	705.00	737.50	760.00
AFDC Need Standard	312.00	312.00	312.00	312.00	312.00
Payment Standard	261.00	261.00	263.00	274.00	279.00

Buy-In

As a cost saving measure, a Buy-In provision was added in 1968 whereby the Supplementary Medical Insurance premium (Title XVIII B of the Social Security Act) is paid for all cash recipients of Old Age Assistance, Permanently and Totally Disabled, Aid to the Blind, and Aid to Families with Dependent Children who meet the criteria guidelines for Medicare. This permits the State to shift the largest portion of these recipients medical expenses to the Medicare Program with the State's responsibility being reduced to the deductible and coinsurance amounts.

Covered Services

Covered services fall into two categories -- mandatory (services which the federal government requires states to provide) and optional (services which the states may provide at their discretion). The following list delineates the services covered and the month/year they were added as an available service by the Missouri Medicaid Program:

MEDICAID COVERED SERVICES

Mandatory:

Inpatient Hospital (11/67)
Outpatient Hospital (11/67)
Physician (11/67)
Lab/X-ray (11/67)
SNF over 21 (11/67)
Home Health over 21 (2/72)
EPSDT (2/72)
Family Planning (7/73)
Nurse Midwife (12/87)

Optional:

Adult Day Care (7/83)
Alternative (Adult Waiver) Services Over 65 (7/82)
Ambulance (7/69)
Ambulatory Surgical Center
Audiology (6/79)
Childrens Waivered Services under 21 (1/84)
Clinic (8/79)
Dental (11/67)
DME (5/78)
Home Health Under 21 (2/72)
ICF (1/74)
ICF/MR (10/75)
Medicare Part B (1968)
Optometric (10/72)
Personal Care (7/82)
Pharmacy (11/67)
Podiatry (7/79)
Psychiatric Under 21 (6/81)
Psychiatric Over 65 (11/67)
Rehabilitative Services (8/79)

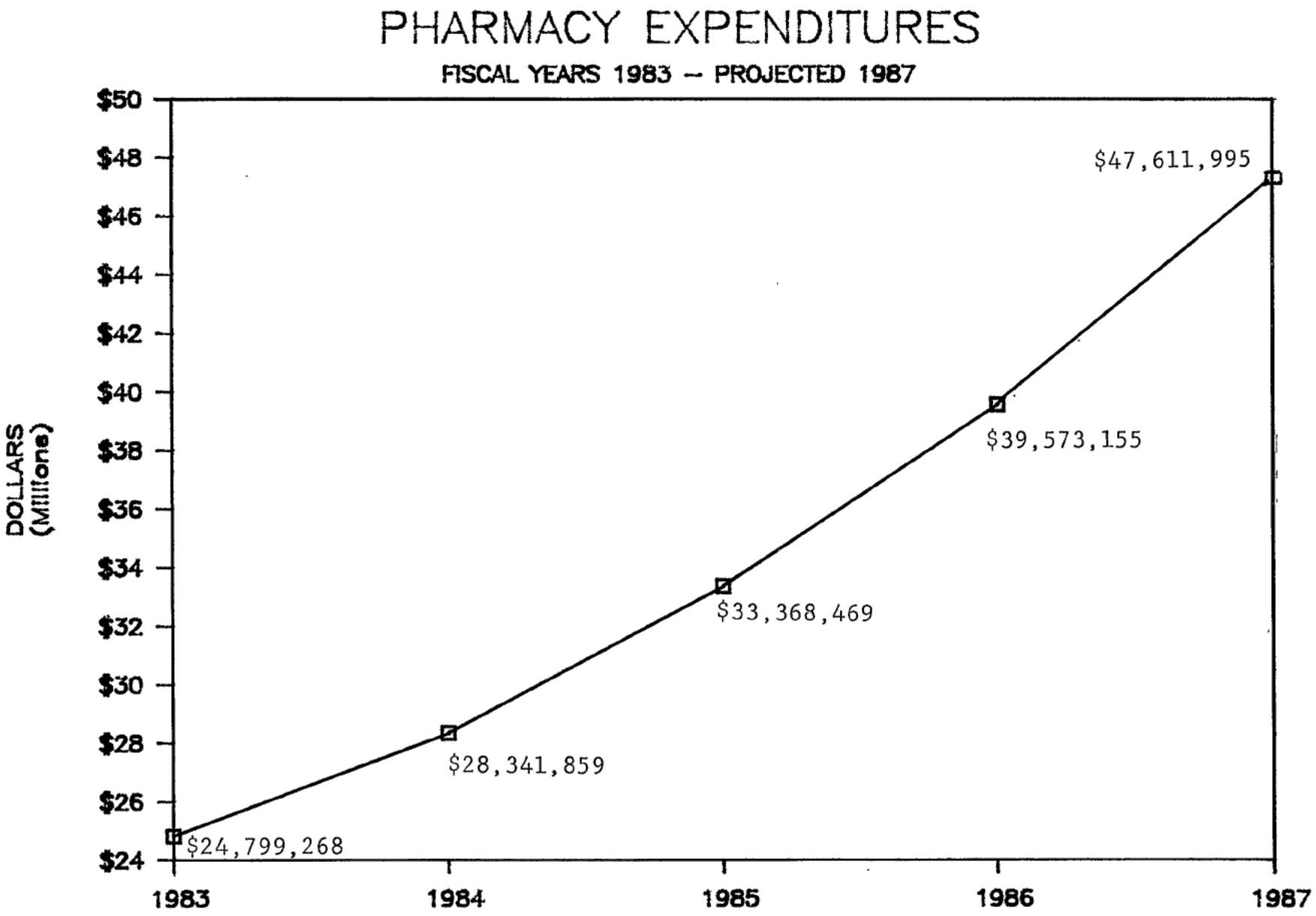
Program Expenditures

Expenditures for the Medicaid Program have shown a dramatic increase over the last several years. The amount appropriated for the program in State FY-68 was $19.4 million. Total program costs for FY-76 were $129.9 million. By FY-86, costs had risen to $536.2 million. The original appropriation for State FY-87 (July 1, 1986 through June 30, 1987) was $558 million. However, a supplemental appropriation of $29 million was also received. Of this amount, State General Revenue funds account for $234 million.

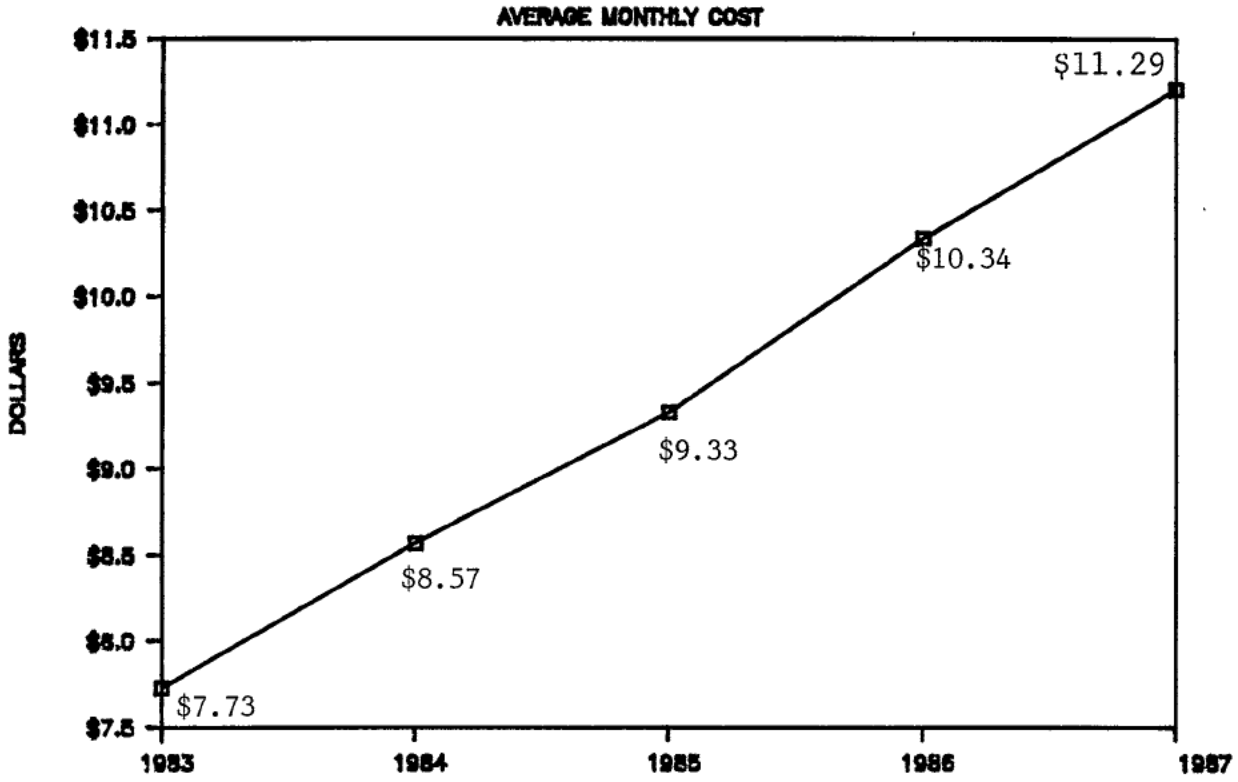
One of the significant trends in the program was the rapidly mounting cost of institutional care. To illustrate, hospital care rose from $28 million in FY-73 to $73 million in FY-78. From FY-79 to FY-81, the annual percentage increase was 23 percent. In the State's current fiscal year, hospital expenditures are expected to reach $192 million.

In FY-75, an intermediate care facility (ICF) program was implemented which shifted the emphasis from skilled nursing home care to intermediate care services. As a result, in FY-79, the skilled nursing home patient load dropped to less than 400 patients, while the ICF load, by FY-81, exceeded 14,000 patients. Because of a change in federal law, the agency adopted a cost-reimbursement plan for nursing homes, effective July 1, 1976. The twenty million dollar expenditure for FY-75 rose to $55.7 million dollars in FY-78. Current spending for nursing home care is expected to be approximately $260 million.

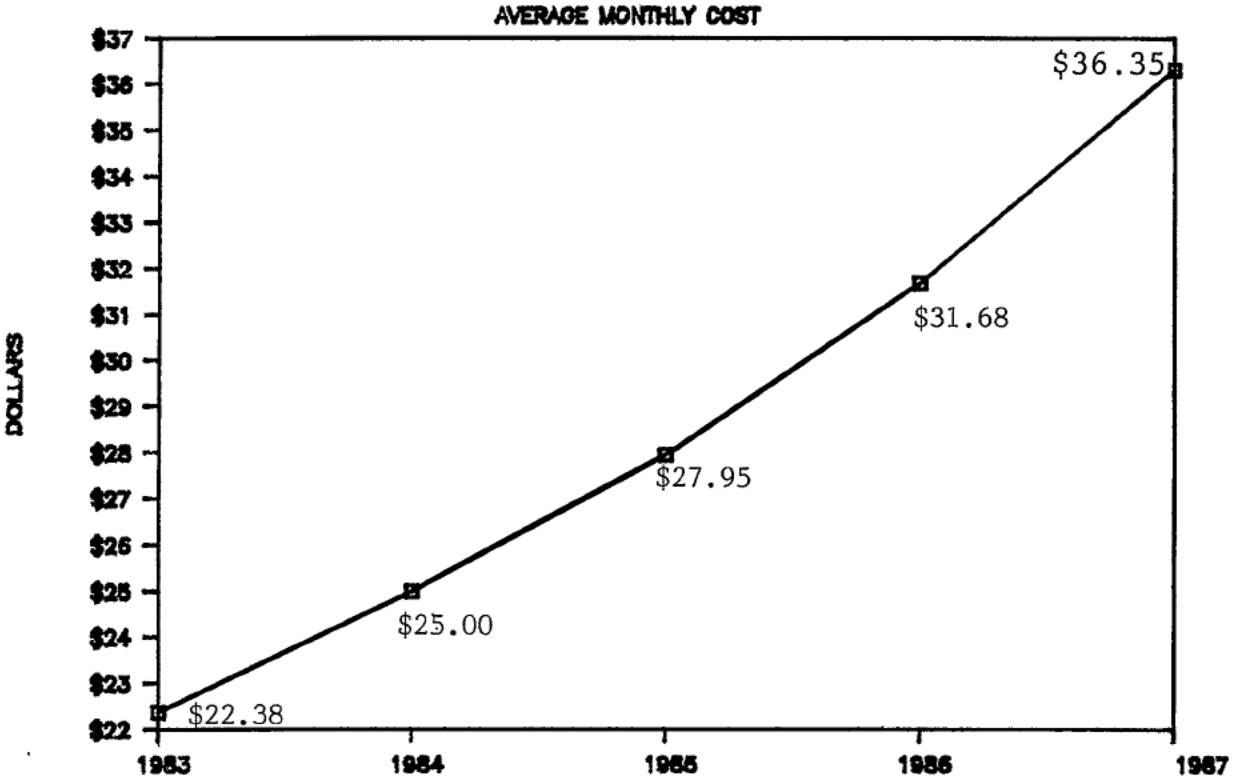
Another aspect of the program is the Missouri Medicaid Formulary, which is the listing of pharmaceutical supplies for which the Medicaid Program will provide reimbursement. Pharmacy expenditures have doubled since FY-83 ($24 million to almost $48 million in FY-87). Part of this growth is attributable to the increase in the drug ingredient cost. In addition to the cost of the drugs, pharmacies receive a dispensing fee for each prescription filled. The dispensing fee was raised from $2.50 per prescription to $2.75 in 1985 and will be increased to $3.00 in 1988. This also is reflected in the increased cost of the program. The increase in the Pharmacy Program can readily be seen in the following graphs.


PHARMACY EXPENDITURES
FISCAL YEARS 1983 – PROJECTED 1987
DOLLARS (Millions)
$50
$48
$46
$44
$42
$40
$38
$36
$34
$32
$30
$28
$26
$24
$24,799,268
$28,341,859
$33,368,469
$39,573,155
$47,611,995
1983
1984
1985
1986
1987

PHARMACY COST PER PRESCRIPTION



PHARMACY COST PER USER

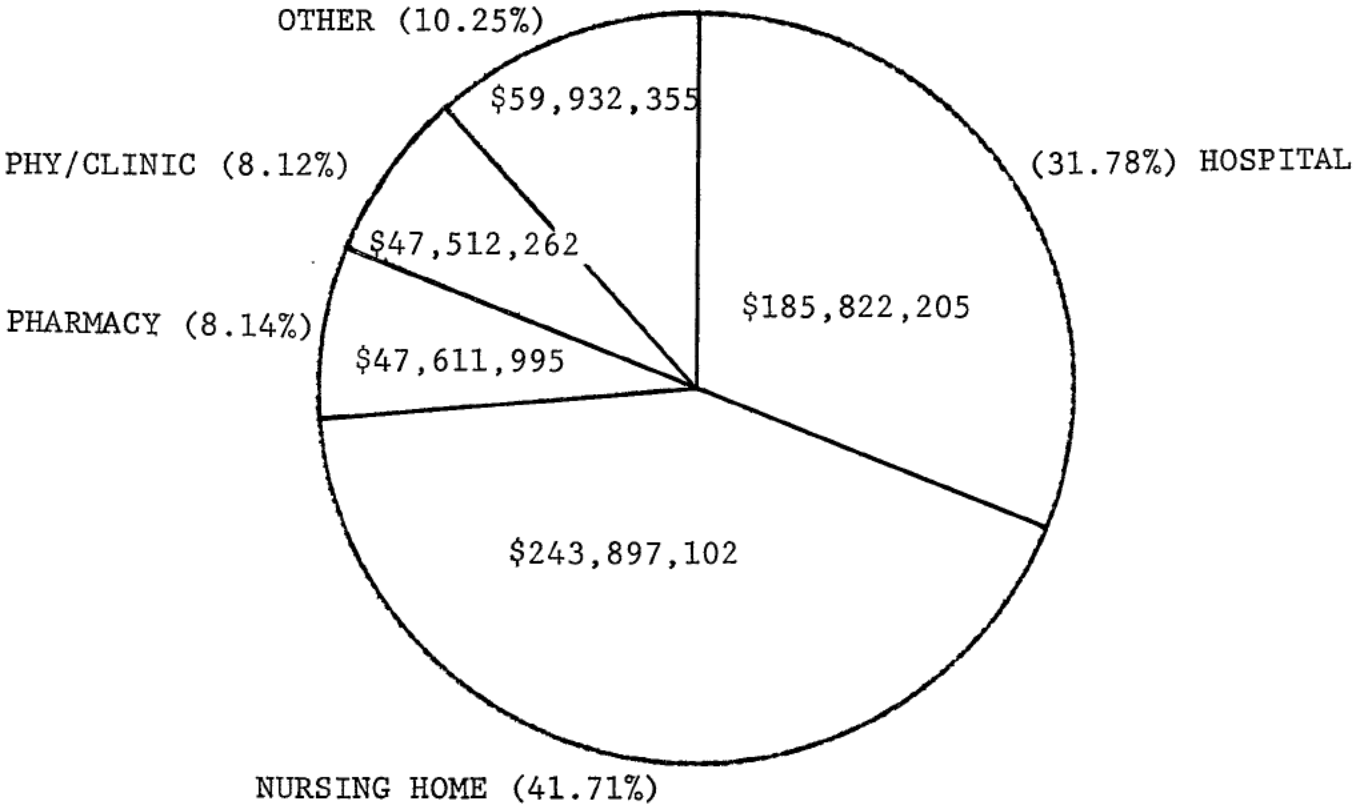


In order to curb the spending growth of the Medicaid Program, several cost containment measures have been adopted since 1981. Prospective rate plans were established for hospitals and nursing homes, limits were placed on the utilization of services and reimbursement levels were established for certain services. New financial incentives to promote primary care were incorporated for physicians.

Additionally, Missouri's AFDC Prepaid Health Plan in Jackson County was established in 1983, whereby reimbursement is based on a monthly capitated amount, actuarially determined, rather than the traditional insurance model of fee-for-service. General Relief recipients in St. Louis City have had their services provided under a capitation plan since January 1982.

Community Based Waiver services were authorized by the Department of Health and Human Services in 1981. In general, the waiver offers Medicaid support to the chronically impaired elderly living in the community who, without such services, would require the level of care (and increased cost) provided in an intermediate care facility (ICF). During the waiver year ending April 1986, 3,700 recipients were served under the waiver program at a cost of nearly $4 million; however, the comparative cost would have been approximately $28,907,550 if institutionalized.

Since 1967, the Medicaid Program has grown from a $19.4 million program to a $584 million program in FY-87. The following chart shows a breakdown of expenditures by program for fiscal year 1987 (ended June 30, 1986).



Funding

Funding for Medicaid services is provided each fiscal year through appropriations recommended by the State's General Assembly and approved by the Governor. The primary appropriations have traditionally been divided into three main categories: hospitals; nursing homes; and non-institutional services, a term for all services not in the other two categories, with physician and pharmacy services having the higher expenditure costs.

State General Revenue funds, expended on behalf of Title XIX recipients, are currently matched by the federal government at the rate of 59.27%. The federal matching rate, which is established by the federal government, is based on the relationship between each state's per capita personal income and that of the nation as a whole for three previous years. States with lower per capita incomes receive higher federal grants. The federal share cannot be lower than 50% nor higher than 83%. Beginning federal fiscal year 1988, this rate will be updated on a yearly basis. In addition to Title XIX recipients, there are individuals who receive medical services through the State Medical Assistance Program. The State Medical Assistance Program is funded entirely by General Revenue funds (approximately 3% of total expenditures). The program has expanded its base during this period, covering a wide spectrum of health care users and available services.

In fiscal year 1987, the hospital program appropriation, including supplemental appropriations, was $175 million; nursing home, $245 million; and non-institutional was allotted $144 million. The total of all appropriations was $587 million.

Provider Participation

Medicaid provides certain medical benefits to eligible public assistance recipients in accordance with federal and state laws. These services are provided by approximately 22,000 enrolled Medicaid providers participating in the program, who submit in excess of 10 million claims per year. The types of providers presently reimbursed by Medicaid are as follows:

- Physicians and Podiatrists;
- All types of Clinics, Family Planning, Public Health, etc.;
- Dentists, Optometrists, Opticians;
- Hospitals, Nursing Homes, Home Health Agencies, Homemaker Chore Providers;
- Pharmacies, Ambulance Companies;
- Durable Medical Equipment Suppliers; Audiologists and Hearing Aid Dealers;
- Personal Care Providers, Ambulatory Surgical Care Providers, Surgical Care Providers, Adult Day Health Care Providers;
- Independent Laboratories and Radiologists;
- Rehabilitation Centers;
- Nurse-midwives.

Providers who participate in the Medicaid Program agree to accept Medicaid payment as payment in full for any services provided to Medicaid recipients. The provider cannot bill the recipient the difference between the Medicaid payment and the provider's billed charges. The provider has the option, however, to bill the recipient for services not covered by Medicaid or for services provided on a date when a recipient was not eligible for Medicaid.

DATA RESOURCES:

DSS Monthly Administrative Analysis, Table 5, Medical Statistics
Division of Medical Services, Standard Data Set.